REPORT

on

FUTURE DIRECTIONS FOR PSYCHOGERIATRIC SERVICE DELIVERY

in

MANITOBA

Manitoba Health

Submitted by:
The Psychogeriatric
Planning Committee
March, 1988

We, the undersigned, respectfully submit this report on Future Directions for Psychogeriatric Service Delivery in Manitoba and would strongly encourage immediate action on the implementation of the recommendations contained herein.

Beth Atchison, M.D.,F.R.C.P.(C)

Don Gibson, M.S.W.

Eckhard Goerz, B.A.,M.S.W.

Betty Havens, M.A.

Edie Heinrichs, B.N.

Anwar Islam, Ph.D.

Mike Kufflick

Marg Redston, R.N.

Maxine Topley, M.S.W.

Tom Walters, M.S.W.
Chairman

TABLE OF CONTENTS

		PAGE
1.	Executive Summary	i
2.	Introduction	1
	2:01 Terms of Reference of Committee	2
	2:02 Methodology	3
3.	Scope of Problem	5
	3:01 Demographic Data	5
	3:02 Epidemiological Studies	8
4.	Psychogeriatric Services: Past, Present and Future	16
	4:01 Historical Overview of Psychogeriatric Service Development in Manitoba	16
	4:02 Existing Services	19
	4:03 Organizational Structure and Funding Mechanism	29
	4:04 Existing Human Resources	32
	4:05 Gaps in System	35
	4:06 Target Population	41
	4:07 Conceptual Model	43
	4:08 Service Principles	57
5.	Conclusion and Summary of Recommendations	59
	References	
	Appendices	

1. EXECUTIVE SUMMARY

The projected increase in the elderly population by the year 2001 has stimulated the health and mental health care fields to closely examine the implications for present service delivery. In order to plan effectively in mental health, a psychogeriatric planning committee was struck to assess the current and projected mental health needs of elderly Manitobans and to develop a viable model for the delivery of psychogeriatric services.

This is a summary of the content of the report. For a complete understanding of the model and recommendations set forth, the report must be read in its entirety.

General Mental Health Reform

Present service delivery to the psychogeriatric population is fragmented and reflects the structural and administrative deficits of the present mental health system. Therefore, reform in the present system is seen as a prerequisite to implementing well-coordinated, functional psychogeriatric services in Manitoba. Proposed changes in the mental health system that are in the planning stages focus on correcting the following deficiencies:

* lack of a unified organizational structure.
* lack of continuity of treatment between the hospital/ institutional sector and the community sector.
* lack of sufficient community resources.

* heavy reliance on hospital/institutional treatment.
* regional disparities.

Target Population

Because of the specialized nature of the service proposed in the model, it is necessary to clearly define the target population, particularly in light of the number of people that are presently served by the general mental health system and who will grow old. The target population in order of service priority is as follows:

* people who experience the first onset of mental illness at the age of 65 or over.
* people who are under the age of 65 and whose cognitive impairment is related to a disease associated with aging.
* elderly people who have experienced mental illness throughout their lifetime and, due to the interaction of the course of the disease together with maturation, require the specialized services of psychogeriatrics.
* elderly people with the dual diagnosis of mental illness and mental retardation.

Development of Model

In formulating a model for the delivery of psychogeriatric services, the lack of a comprehensive data collection system impeded a detailed analysis of mental health needs of elderly people. The need for this analysis remains outstanding and will have to be undertaken as part of a longer term planning/implementation process.

The model that is proposed for delivering psychogeriatric services in the province is based on a specialized service component being built into the existing

service network (model depicted on page 46). The model itself is not intended to duplicate or parallel existing services, but rather to utilize them in the delivery of a comprehensive range of services to meet the multiple and changing needs of elderly persons. This model is in keeping with the federal and provincial guidelines for service development, reflecting the following characteristics:

* multi-disciplinary nature of services.
* community-based service delivery and resource sectors.
* a broad range of services to meet the multiple needs of elderly persons.
* easy accessibility of services.
* effective coordination of services.

The proposed specialized service component of the model is regional, community-based multi-disciplinary teams which provide a broad range of services from prevention, assessment and treatment through to consultation and education. Wherever possible, active treatment remains with the referring professional, whose ongoing case involvement is enhanced or augmented by the expertise of the team.

Vital to the operation of the model is regional planning capacity with standard setting and quality assurance remaining with central office. Necessary service principles guiding the development of psychogeriatric services are outlined in the report to ensure consistency between regions and between the hospital/institutional community sectors.

Recommendations

The following recommendations were identified in terms of their requirement for immediate action, further planning and further planning with fiscal implications:

* improved data collection systems and strengthened research endeavours.
* formal service linkages between key sectors in mental health.
* unified administrative and fiscal structures in mental health.
* adequate training opportunities for all disciplines in psychogeriatrics.
* expanded community resource base.
* clearly specified target population.
* funding of two pilot projects, implementing the model for delivery of psychogeriatric services.
* a senior position in the Mental Health Division allocated to plan and coordinate the psychogeriatric service delivery in the province.
* adoption of service principles to guide future development of psychogeriatric services.

Due to increasing demands of the expanding elderly population on the mental health system, immediate action on the implementation of these recommendations is strongly encouraged by the Committee.

2. INTRODUCTION

Since the evolution of psychogeriatrics* three decades ago, there has been no clear direction or policy guidelines for the development of these specialized services in Manitoba. To date planning and implementation of these services has occurred at random, resulting in a fragmented and under-developed service delivery system.

Population projections predict a substantial increase in the over 65 age group by the year 2001. As this population expands, there will be greater pressure on all areas of the service delivery system to respond to the concomitant increase in needs, particularly in mental health.

In order to ensure a solid foundation for the future development of psychogeriatric services in the province, Senior Management of Manitoba Health approved the formation of a planning committee in 1986.

* The terms psychogeriatrics, geropsychiatry or geriatric psychiatry are used interchangeably throughout the professional community. For the purpose of this document they refer to the multi-disciplinary practice in the assessment and treatment of elderly people with psychiatric disorders.

2:01 Terms of Reference of Committee

The Planning Committee was given the following terms of reference to accomplish its goals:

a) a review of existing and proposed resources to identify gaps and problems in service delivery;
b) a clear articulation of the target population of psychogeriatrics;
c) an analysis of the present and projected mental health needs of elderly Manitobans;
d) the development of service delivery models for psychogeriatrics; and
e) a strategy for implementation of these models.

The committee itself was comprised of representatives from both the Department of Health and Manitoba Health Services Commission, and an external psychogeriatric consultant in order to address the need for integration of the community/hospital sectors in the planning process (refer to Appendix I: Membership of Committee).

The Mental Health Directorate spearheaded the formation of the committee and was commissioned with the task of chairing it in order to ensure overall coordination.

2:02 Methodology

The Planning Committee established its own internal process to guide the planning of a psychogeriatric service delivery model for the Province. The following steps were undertaken to complete the terms of reference:

Phase I: Data Collection

1. Compilation of existing statistics/programs: epidemiology, population projections, psychiatric staffing, training programs, fiscal expenditures, hospital utilization, updated statistics on Gordon/Zloty study, M.H.S.C. programs presently funded and approved for funding, mental health centres psychogeriatric programs.

2. Review of existing service models (provincial/national/international).

3. Conducted surveys on regional needs: Continuing Care Survey, Community Mental Health Survey, Survey Update of 1983 Survey on Aging in Manitoba.

4. Review of relevant reading materials: Federal Guidelines for Comprehensive Services to Elderly Persons with Psychiatric Disorders (draft), Ontario Report on Alzheimer's Disease,and numerous articles on treatment and care of the elderly.

Phase II: Identification of Gaps and Issues

Phase III: Development of Conceptual Service Delivery Model and Policy Guidelines

Phase IV: Formulation of Implementation Strategies and Priorization for Implementation

For the purpose of guiding the actual development of the model, the Planning Committee utilized the Federal Health and Welfare draft "Guidelines for Comprehensive Services to Elderly Persons With Psychiatric Disorders" (see

Appendix XIII: Health & Welfare Canada Guidelines for the Development of Comprehensive Services to Elderly Persons with Psychiatric Disorders).

Throughout the planning process, committee members' expertise both in the field of psychogeriatrics and in their respective program areas was drawn upon heavily. This was further enhanced by the broad range of disciplines represented on the committee, which included nursing, social work, sociology, administration and psychiatry.

External resources were utilized for the purposes of data collection and informal feedback on the model. The use of external resources was integral to the planning and proved not only to be a vital supplement to the scant information available in the field, but also invaluable in refining the model.

3. SCOPE OF PROBLEM: PRESENT AND FUTURE

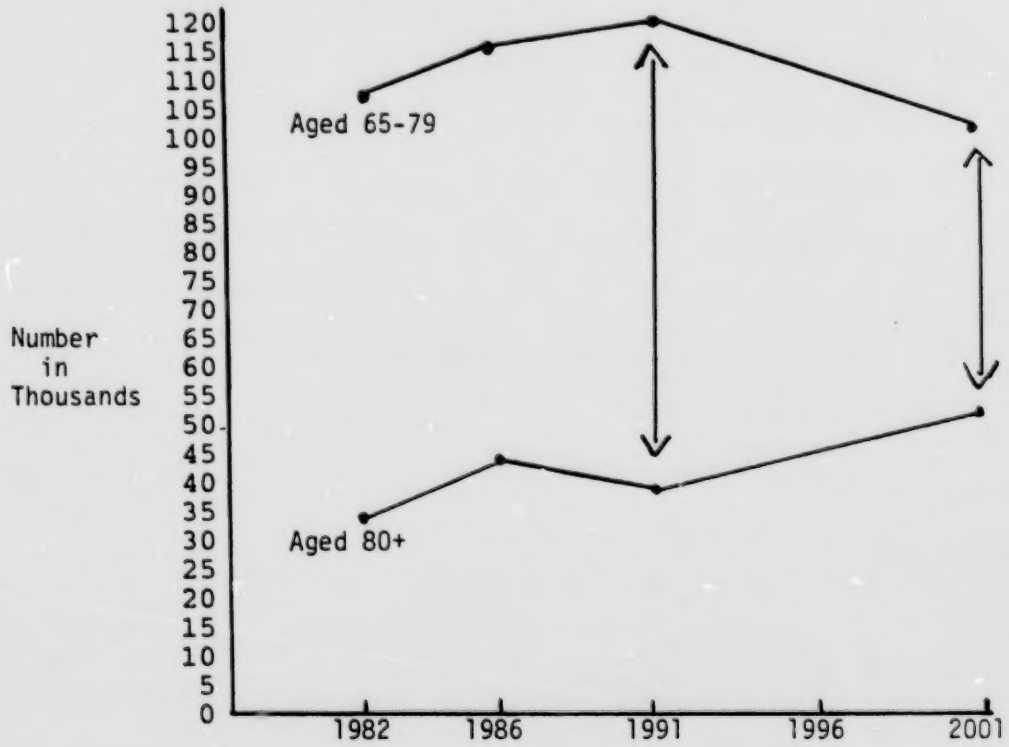
It is a well-documented fact that there will be an increase in the elderly population by the year 2001. On the basis of this projected change in the population profile, it can be assumed that there will be increase in the mental health needs of elderly people by virtue of the increase in numbers. It becomes difficult, however, to predict if the rate of increase in mental health needs will be in direct proportion to the numbers. Rapid advances in medical technology, dramatic alternations in the delivery of health care and a myriad of potential socio-economic-political changes are major variables that will have an impact on future needs.

With this in mind, it was necessary to review the existing data on population trends and current epidemiological studies, in order to ascertain the scope of the problem. Projections were made on future directions, acknowledging the number of factors that could potentially alter the analysis at this point in time.

3:01 Demographic Data

By the year 2001 there will be a projected increase in the population of the age 65 and over group from 11.8% to 12.1% of the total population in Manitoba (see Appendix II: Population Projections for Manitoba). When this age group is broken down, the group of 65-79 years of age will peak in 1991 and begin

to decline by 2001. Whereas, the group of 80 years of age and over will increase by 2001. The following graph depicts these figures:



The implications of the projected increase in the 80+ age group are extremely important to the planning of health care, including mental health, due to the following reasons:

* highest medical risk of any age group.
* positive correlation of physical disease and mental disorders.
* reduction in elderly person's support network such as friends and family.
* diagnostic difficulties with elderly persons.

These implications suggest the need for more intensive health and mental health services to the over 80 age group with particular focus on home-based

services to address the gap traditionally filled by an elderly person's support network.

Projections in the population distribution also become significant in the planning process. The following projections by region have been calculated:

PROJECTED PERCENTAGE DISTRIBUTION OF 65+ AGE-GROUP
BY REGION

YEAR	SOUTH EAST	SOUTH CENTRAL	SOUTH WEST	NORTH CENTRAL	WINNIPEG	INTERLAKE	PARKLANDS	NORTH	MANITOBA
1987	10.65	15.01	16.82	13.51	12.76	12.68	17.56	4.75	12.8
1991	11.00	15.52	17.38	13.96	13.64	13.28	18.22	5.03	13.4
1996	11.34	15.64	17.69	14.26	14.62	13.87	18.26	5.53	14.2
2001	11.62	15.36	17.60	14.45	15.33	14.52	17.63	6.25	14.8
2006	11.97	14.86	17.22	14.68	15.91	15.14	16.70	7.21	15.3

Source: Manitoba Bureau of Statistics,
Regional Population Projections, 1985-2006
December 1985
(Revised)

These projections are useful in determining the allocation of resources to regions with the greatest projected increase in elderly, in establishing priorities in the budget process, and in supplying data for sound, long-term planning.

3:02 Epidemiological Studies

A review of the epidemiological studies on mental disorders in the elderly provides more specific data in the planning of the scope and kind of resources required to meet the mental health needs of Manitobans.

However, it should be noted that very few epidemiological studies on the elderly originate in Canada and, therefore, must be applied to the Canadian scene with some degree of discretion.

I. General Findings

In epidemiological surveys examining the elderly, the frequency of occurrence of mental disorder is noted to be higher overall than in younger age groups. When the rates for new cases of psychopathology from the National Institute of Mental Health in the United States are applied to Canada, the following incidents of psychopathology appear in the population (1):

AGE GROUP	RATE/ 100,000 POPULATION	NUMBERS IN CANADA				
		1987	1991	1996	2001	2006
<15	2.3	129	132	131	124	118
15 - 34	76.3	6,729	6,520	6,194	5,978	6,007
35 - 64	93.0	7,955	8,642	9,673	10,633	11,184
65+	236.1	6,332	6,985	7,598	7,998	8,327
		21,146	22,279	23,596	24,733	25,636

These rates include all mental disorders regardless of etiology or natural history of disease. Since physical disease does occur with increasing frequency as populations age, this accounts partially for increasing rates of mental disorder with age.

When these rates are compared to Canada's existing and projected populations, there is an even greater increase in the age 65 and over group, as depicted in the following graph:

POPULATION PROJECTION FOR CANADA:
1987 TO 2006 BY SELECTED AGE-GROUPS
LEGEND
UNDER 15 YEARS
15-34 YEARS
35-64 YEARS
65+
POPULATION IN THOUSANDS
20000
18000
16000
14000
12000
10000
8000
6000
4000
2000
0
1987
1991
1996
2001
2006
YEARS

General population surveys estimate 15-30% (2,3,4) of the elderly population to have some need for psychiatric service, while a very small proportion of this group appear to seek or receive such intervention (5). Samples from other than community settings, i.e. hospital, nursing home, generally show higher rates of psychiatric illness (6,7) although the diagnostic mix tends to be different. For example, a nursing home would likely show a higher prevalence in the organic mental disorder group than affective disorders with the opposite picture seen in a community sample or psychiatric in-patient sample.

General statistics regarding suicide rates identify 25% of all completed suicides as being committed by those 65 years of age and older (8) with the highest age group incidence occurring in white males over 80 years of age. Given the percentage population represented by the elderly age group, this suicide phenomenon indicates a serious mental health issue (9,10), since suicide is most highly correlated with the presence of depression, which is a treatable disorder.

II. Specific Findings

There are three major diagnostic categories which tend to account for the bulk of mental disorders in the aged as follows:

a. Affective Disorders

Overall, affective disorders (mostly depression) are the most prevalent in the aged population, accounting for approximately one-half of all mental disorders in the elderly (11). Several researchers have suggested that the incidence of depressive illness may increase with age, in part due to physical maturation and often dramatic changes in life circumstance.

Community studies show a fairly wide variation. For example, a number of Scandinavian community surveys identify relatively low prevalence rates ranging from 2-6%, while several North American and British studies cite rates ranging from 7-44% (12).

Rates observed in institutional and clinic populations tend to be higher, estimated to be approximately 30% (13).

b. Dementia

Data from community samples indicate prevalence rates of dementia ranging from 2-5% of all individuals aged 65 and over. These rates are observed to rise with age to estimates of about 20% of the population over 80 years of age (13). These rates are particularly significant in view of demographic shifts noted in the 80+ age group. Prevalence of dementia is higher in clinical and

institutional samples with rates ranging between 30-54% (14).

A breakdown of the dementia group suggests that about 50% of cases are caused by Alzheimer's disease, 20% by multi-infarction disease and the remainder due to other causes with 15% stemming from curable diseases. This suggests that 75-80% of dementias are not curable and, therefore, require development of services to provide long-term follow-up, while about 20% have the potential for partial or complete treatment.

c. Delirium

Prevalence rates of delirium have been reported as follows: (16)

Setting	% cases amongst Elderly Patients
Psychiatric in-patient units	10-50%
Neurological units	40%
General medical/surgical units	14-30%

Morbidity and mortality rates in untreated delirium are relatively high and a certain proportion appears to progress to irreversible dementia.

d. Other disorders occur in elderly populations but are more difficult to characterize as they often are a manifestation of a chronic disorder that began earlier in life. An example of this is

the schizophrenic disorders which in terms of overall incidence and prevalence are rare yet frequently produce dysfunction of such severity to require heavy medical, hospital and community services throughout the individual's life. The lifetime risk of schizophrenia in the general population is about 1%.

Alcoholism rates in the general elderly population range from 2-10%. It was suggested that only 10% of these cases arise in late life with the bulk having an earlier onset. A similar trend is observed in other substance abuse disorders. It is possible that, as the population continues to mature, the prevalence rates of alcohol and other substance abuse disorders will rise (13).

Since there are few epidemiological studies conducted in Canada and none in Manitoba, it is difficult to apply the available statistics to Manitoba with any degree of reliability. Research in this area also tends to be limited, which in turn has an effect on the clinical aspect of service delivery.

Due to this insufficient data and research base, a detailed analysis of the needs of the psychogeriatric population will have to be undertaken.

Recommendations: Data Collection and Research

1. Improvements be made to existing data collection systems that will allow for expansion and standardization of present data.
2. Research into psychogeriatrics be encouraged through redirection of existing research monies.
3. A comprehensive needs analysis of psychogeriatric population be undertaken in each region as part of the long range planning process.

4. PSYCHOGERIATRIC SERVICES: PAST PRESENT AND FUTURE

In order to plan a comprehensive service delivery system in psychogeriatrics it is essential to understand the system as it presently exists and how it evolved. This understanding may then be optimally utilized to create a structure, which will accommodate the growing demands of the elderly as a group.

4:01 Historical Overview of Psychogeriatric Service Development in Manitoba

Geriatric Psychiatry began to gain recognition as a separate field in the 1950's with the publication of Sir Martin Roth's study on the natural history of mental disorder in the elderly. Prior to this, mental illness in old people was largely regarded as a single entity caused by cerebral aging, inevitably leading to dementia and death.

As the knowledge base expanded in Geriatric Psychiatry, specialized services began to emerge. The most active movement in the development of these services occurred in Great Britain (17). It was there that the major impetus towards comprehensive, integrated community/hospital services was implemented.

In North America psychogeriatric services evolved somewhat differently due to the fundamental differences in the health care systems. Despite these differences, the common element that emerged was the need for

integration in the community/hospital sectors in the design of psychogeriatric services.

In Manitoba the first psychogeriatric program to be funded was at the Seven Oaks General Hospital. Prior to this, the existing services in the hospital/ community sectors dealt with elderly people with psychiatric disorders. Specialization occurred on an interest basis, but was not given a formal mandate within the service delivery system. However, the informal network that arose gave impetus to the development of more specialized services, one of the main thrusts emanating from the St. Boniface General Hospital, Departments of Psychiatry and Geriatric Medicine.

The development of the Seven Oaks Psychogeriatric Program in 1985 marked the first official move towards specialized comprehensive service delivery. Unique at the time to the Seven Oaks Program was the community outreach program which was developed as an integral part of the overall service delivery. It was based on the recognition that intervention into problems at a community level could effectively reduce the severity and the need for costly hospitalization.

This program offers comprehensive clinical assessments incorporating the combined efforts of Geriatric Medicine and Psychiatry, as well as a broad range of services, including day hospital, in-patient

assessment and treatment, and community consultation and treatment planning/implementation.

Following the development of the Seven Oaks Psychogeriatric Program, Deer Lodge Centre began to operationalize plans for a comprehensive psychogeriatric service, including a day hospital, a day program for the cognitively impaired and a community team. An in-patient assessment unit was planned, but is currently not operational. Unique to the Deer Lodge program is the sequencing of the development of the community psychogeriatric team prior to the development of its in-patient facilities.

Specialized psychogeriatric services also began to emerge in the institutional sector in the mid 1980's with the Brandon Mental Health Centre developing a 12 bed psychogeriatric unit and with a number of specialized programs developing in personal care homes.

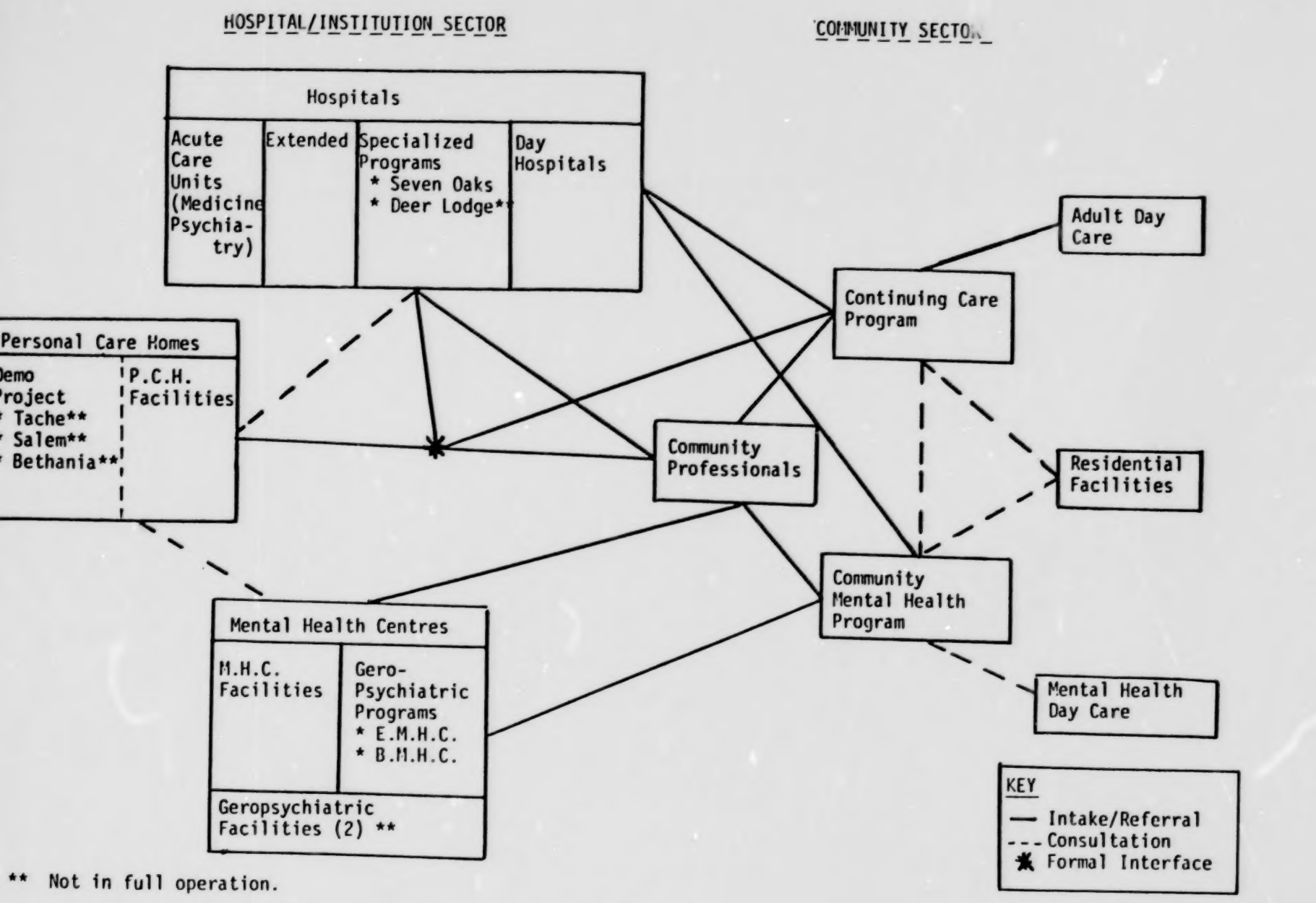
In analyzing the historical development of psychogeriatric services in Manitoba, the two major trends towards increased specialization of services and development of community outreach services from a hospital base are of importance to the overall future direction of psychogeriatric service delivery. Also, the formalized integration of community and hospital services marks a general shift in the evolution of service development, which has traditionally fostered autonomy of these two sectors. While this shift can be

most clearly seen in the field of psychogeriatrics, it is the trend for the future.

4:02 Existing Services

As mentioned in the previous section, an informal network arose in the field of psychogeriatrics in Manitoba, providing the major thrust towards specialized services. Because of the instrumental role some of these services play in psychogeriatrics, they are an important part of the existing service network. The following diagram depicts the major service sectors, the key services within each sector, and the interrelationship of the key components:

PRESENT SERVICE DELIVERY TO PSYCHOGERIATRIC POPULATION: INTERRELATIONSHIP OF KEY COMPONENTS



** Not in full operation.

a) Hospital/Institutional Sector

This sector is comprised of three major areas: Hospitals, Mental Health Centres and Personal Care Homes. Within this sector hospitals have the most diverse contact with seniors, covering a wide spectrum of emergency care, geriatric medicine, general medicine, surgery, psychiatry and day hospital programs. All of these areas come into contact with psychiatric problems in the elderly.

There are two hospital facilities with specialized psychogeriatric services: Seven Oaks General Hospital and Deer Lodge Centre. Since these hospitals have defined catchment areas, they do not service the entire province, although referrals are accepted from outside the catchment area as space allows. Both these services are too new to accurately assess the overall impact on the service delivery system to seniors.

Other general hospitals provide some form of psychiatric treatment to the elderly patient, either on a psychiatric unit or on a medical ward. The most dramatic difference in the service delivery of the mental health system occurs between urban (Winnipeg and Brandon) and rural areas. In urban areas six out of the seven

hospitals have psychiatric units, which offer general adult psychiatric treatment albeit non-specialized for the most part; in general hospitals located in rural areas, psychiatric treatment is administered through general medicine via general practitioners, some of whom may have access to psychiatric consultation. While this lack of psychiatric services and limited access to psychiatric consultation plagues all age groups requiring psychiatric treatment in rural areas, it is more acutely apparent in the elderly population, who often pose complex diagnostic problems.

Hospitals in urban areas also have a broader range of services which include partial hospitalization through their day hospital programs. Of the six geriatric day hospital programs in operation, two are designated for psychogeriatrics, Seven Oaks and Deer Lodge, although all deal with psychogeriatric clientele (refer to Appendix III: Day Hospitals: Psychiatric Problems in Elderly Patients). Both the Seven Oaks and Deer Lodge programs have formal linkages to the community sector through Continuing Care and Community Mental Health. Deer Lodge also has an Adult Day Care Program for the cognitively impaired.

Within the spectrum of hospital/institutional services Personal Care Homes (P.C.H.'s) have significant contact with mental health problems. It is estimated that an average of 28% of all residents have mental health problems (refer to Appendix IV: Percentage of Personal Care Home Residents by Region With A Primary Psychiatric Diagnosis). A relatively small number of P.C.H.'s have been able to arrange for the ongoing services of a psychiatrist. For the most part, these problems are dealt with by staff with limited expertise and training in psychiatry and even less expertise in psychogeriatrics.

Persons qualify for admission to Personal Care Homes when their care needs can no longer be adequately met in the community. This is determined by a panelling process organized and conducted by the Continuing Care Program. The process involves a multi-disciplinary assessment to ensure appropriate admissions in respect to care level, culture, language and geography. Priority for admission is based on client/family needs including medical, psychiatric and/or behavioural, and social problems.

In an endeavour to deal with personal care home residents with psychiatric and/or behavioural problems, a number of innovative approaches have

been adopted by some facilities. Two approaches within the personal care home sector that have received special funding are located at Tache Nursing Centre, where a full-time psychologist consults to staff, and at Bethania and Salem P.C.H.'s, where two ten-bed units are planned for residents with the aforementioned problems.

The final component in the spectrum of hospital/institutional sector is the mental health centres. In the two largest facilities, Brandon and Selkirk, the elderly patients account for 42% of the population. Many of these patients have grown old in the institutions. Brandon will be opening a 100-bed psychogeriatric facility shortly with future plans for a similar facility at Selkirk.

In terms of other specialized programs at the centres, the Brandon Mental Health Centre established a Psychogeriatric Assessment Unit in 1986 that provides evaluation and short-term treatment to the elderly referred to the Centre from its catchment area. This 12-bed unit receives consultation from a specialist in geriatric medicine as well as a geropsychiatrist from Winnipeg via an audio visual link the Centre has with the University of Manitoba, Department of Psychiatry. Using the multi-disciplinary team

approach, this Unit's primary objective is to diagnose and formulate a workable plan of care for each geriatric referral within six to eight weeks and then return the patient to his/her community.

The Eden Mental Health Centre in Winkler, considered a rural resource centre to health care institutions and professionals, provides medical, social work and nursing services. While the Centre serves all age groups from adulthood onward, with approximately 40% of the patient population being psychogeriatric.

Working out of the centre is a community psychogeriatric team, comprised of a geriatrician, social worker and nurse, which consults to 28 health care institutions, as well as health care professionals, within Eden's catchment area.

b) Community Sector

The majority of the elderly people with mental health problems who reside in the community are served by a broad range of community professionals. Of these professionals, medical practitioners are one of the single, largest professional groups to have contact with the elderly person. For many, the doctor is the first contact that the elderly person may have with the formal health/mental health care system.

Within Manitoba the two major programs serving the elderly are the Community Mental Health Program and Continuing Care Program of Manitoba Health.

The Community Mental Health Program offers a broad range of generic mental health services, including short and long term therapy, supportive counselling, monitoring, and crisis intervention. Caseloads of elderly clientele vary considerably from region to region with Winnipeg Region having the greatest concentration (refer to Appendix V: 1986 Community Mental Health Cases, By Age and By Region). While there is a beginning trend towards some specialization, the Community Mental Health Program continues to operate from a generic service base that has not provided sufficient specialized training or resources to deal adequately with the specific needs of psychogeriatric cases.

Within the community setting, there are a number of mental health/health resources that can be accessed by the Community Mental Health Program. These resources are comprised of a broad range of residential facilities from board and room facilities to community residences (refer to Appendix VI: Residential Care Facilities), and day programs. Of the day programs, there is only

one program that accepts elderly clients on a regular basis, the 189 Evanson Street Program located in Winnipeg. Again, these resources are not specialized to the psychogeriatric group.

The major portion of the elderly persons receiving care is served by Continuing Care as reflected in the table on page 31. Continuing Care is a major community care program within the Community Health Services Division. This province wide, centrally coordinated, regionally delivered program offers a broad range of health and social services directed to support the care or persons in their own homes and thereby prevent or limit the need for institutional care. Available program resources are: a) direct program funded resources such as Household Support, Personal Care, Nursing, Therapy, social Work, Medical Supplies and Equipment; b) institutionally based resources such as Adult Day Care, Respite Care, access to Day Hospitals and Geriatric Assessments; c) volunteer and community resources - meals delivery, transportation, daily phone checks, friendly visitors, handyman, shopping, etc. Continuing Care is also responsible for the panel process which determines eligibility for admission into Personal Care Homes.

By virtue of the fact that three quarters of its caseload is over the age of 65, the Continuing Care Program deals on a regular basis with mental health problems ranging from mild cognitive impairment to major psychiatric disorders, such as dementia and depression.

In some cases, Continuing Care is the first point of professional contact for the elderly person. As with Community Mental Health, Continuing Care has access to the range of residential facilities for the Aged and Infirm and day care resources for the elderly (refer to Appendix VII: Adult Day Care).

Contact between the Continuing Care Program and Community Mental Health Program occurs on a case by case basis with significant regional variation. This contact may include case consultation, sharing of resources and case coordination.

Recommendations: Key Sectors in Mental Health

4. Linkages be developed between the hospital and community sectors to ensure continuity of care, availability of resources, sharing of information and joint treatment planning.
5. An interface between Continuing Care and Community Mental Health programs be developed outlining the responsibilities of each in the development of resources to respond to the specialized needs of the psychogeriatric client.

4:03 Organizational Structure and Funding Mechanisms

The organization of health services tends to be fragmented due to the complexity of the structures. This fragmentation has posed major difficulties for comprehensive planning, effective coordination and standardization within the mental health system.

In terms of mental health, the key components of the hospital/institutional and community sectors span two areas of the Department of Health: Manitoba Health and Manitoba Health Services Commission (refer to Appendix VIII: Organizational Structure of Health: Key Components of the Psychogeriatric System).

Manitoba Health is divided into the Mental Health Division, containing the Mental Health Directorate and the two mental health centres of Selkirk and Brandon,

and Community Health Services Division, containing the Community Mental Health Program and Continuing Care Program. Each of these divisions has separate administrative structures and fiscal budgets.

The Mental Health Directorate, which reports to the Mental Health Division, is responsible for the planning, coordination and quality assurance of the mental health system. Its only direct financial responsibilities are towards community mental health resources, such as community residences, proctor programs, etc.

Manitoba Health Services Commission is divided into the Urban Facilities Division, Rural Facilities Division, and Long Term Care Programs Division. The Winnipeg and Brandon hospitals and Community Health Centres report to the Urban Facilities Divisions; rural hospitals and personal care homes juxtaposed or jointly managed with hospitals and rural Community Health Centres report to the Rural Facilities Division; Eden Mental Health Centre reports to the Rural Facilities Division; free-standing personal care homes and Deer Lodge Centre report to the Long Term Care Programs Division.

Each division within Manitoba Health and Manitoba Health Services Commission has separate administrative structures and fiscal budgets. While some joint planning does occur within each of the areas of

Manitoba Health and the Manitoba Health Services Commission, there is limited planning between the Department and the Commission. This separation of planning has to some degree fragmented the hospital/ institutional sector and the community sector, particularly between general hospital psychiatric units and the community services.

It is clearly evident from the breakdown of the total health expenditures that the largest proportion of funding continues to be concentrated in the institutional sector of mental health. The hospital/ institutional sector receives an estimated 87% of the total expenditures allocated to mental health service.

Of the remaining budget, the community sector receives 4.4% and medical services (individual medical practitioners) 8.6% (refer to Appendix IX: Manitoba Mental Health Estimated Expenditures For All Ages 1981/82 to 1985/86).

The continued reliance on hospital and institutional mental health services also reflects the evolution of service delivery whose origins are hospital/institutional based. As a result, there continues to exist a strong impetus within the hospital/institutional sector to maintain a homeostatic state.

Recommendations: Organizational Structure and Fiscal Distribution

6. Consideration be given to unifying the key components of the mental health system into one administrative and fiscal structure.
7. A more equitable distribution of fiscal and human resources occur between the hospital/institutional sector and the community sector.
8. A specific allocation of mental health resources be targeted to meet the needs of the psychogeriatric population.

4:04 Existing Human Resources

Within the existing service delivery system to the psychogeriatric population, the major disciplines are represented , predominantly nursing (general and psychiatric), social work, occupational therapy, psychology and psychiatry. It is difficult to estimate the entire number of staff in the health/mental health system who have contact with elderly persons with psychiatric disorders. Within the key components of the health/mental health sector examined in the previous section an estimate of the number of staff by discipline has been calculated (refer to Appendix X: 1985/86 Staffing in Mental Health/Community Health by Discipline and by Work Setting).

Those staff who work in mental health/related health care areas serve the following numbers of elderly people in a twelve month period:

Setting	No. of Cases 65+	No. of Professional Staff
Brandon and Selkirk Mental Health Centres	302(in-pts)	413
Eden Mental Health Centre	194(in and out pts)	20
General Hospital Psychiatric Units	794(in-pts)	339
Personal Care Homes	2,309(with psych. problems)	236
Community Mental Health	1,138	90
Continuing Care	18,885*	350

* Reflects all of the caseload of Continuing Care over the age of 65.

Despite the large number of elderly people served, few staff are adequately trained in psychogeriatrics There are no formal professional training programs that adequately prepare professionals to deal with psychogeriatric problems, including medicine and psychiatry (refer to Appendix XI: Professional Training Programs). Similarly, there are limited opportunities in Manitoba for advanced training in psychogeriatrics. In addition, limited funds are

allocated in existing training budgets for staff development in this area.

This lack of training opportunities, particularly in the basic professional programs, has severely impeded the service delivery sector. Universities and community colleges have traditionally been slow to respond to the changing needs in the human service field. It is this lag that is apparent in the psychogeriatrics field and will pose major difficulties at least in the short-term in the development of specialized programs and recruitment of qualified staff.

Recommendations: Training

9. Manitoba Health invite the universities to participate in the joint development of training, education and research programs in psychogeriatrics where all mental health related disciplines can build knowledge and skills in the care of psychogeriatric clients.
10. Current and future service sites for psychogeriatric services should provide clinical training and inservice/staff development opportunities for practitioners and become an integral part of the proposed training at the universities.
11. Related educational programs be encouraged to incorporate psychogeriatrics as a component of their curriculae.

4:05 Gaps in System

There are a number of gaps in the mental health system that have been identified in such documents, as the Mental Health Working Group Report and the Strategic Plan in Mental Health. It is necessary to recognize those gaps that are inherent and well-documented in the general mental health system, before proceeding to those specific items which pertain to the psychogeriatric population. These gaps include:

* lack of a unified organizational structure

* lack of continuity of treatment between the hospital/institutional sector and the community sector
* lack of sufficient community resources
* heavy reliance on hospital/institutional treatment
* regional disparities

Since recognition and correction of these gaps in the general mental health system is a precursor to a viable psychogeriatric service delivery system, they require further elaboration:

a) lack of a unified organizational structure -

Due to the separate funding and administrative structures previously outlined, overall planning for the mental health system has not occurred. While coordination may take place on a program to program basis, it occurs at random and without a comprehensive plan to guide the process. The discrepancy in mental health expenditures between the hospital/institutional and the community sectors, in part, is a reflection of the resource base of their respective funding structures. Therefore, there is a disproportionate amount of funds channelled to the hospital/institutional sector.

b) lack of continuity of treatment between hospital/ institutional sector and community sector -

While this lack of continuity of treatment has plagued the mental health care in the province,

its effects become compounded in the case of the elderly person where consistency, continuity and familiarity are essential ingredients in care and treatment. To date both sectors have operated on a relatively autonomous basis. Since no formal interface exists between the sectors, case collaboration and joint treatment planning is done inconsistently. Without the mutual exchange of information, assessment and treatment plans are limited in their scope and may lack accuracy and/or comprehensiveness.

Issues of inadequate discharge planning from hospital, lack of coordination and sharing of resources, and poor overall treatment planning arise from this situation. Although more pronounced between sectors, this lack of continuity also exists within each sector.

c) lack of sufficient community resources -

Since the era of deinstitutionalization, the community has not been adequately equipped to treat people within the context of their natural environment. In mental health, this disparity has often resulted in "the revolving door syndrome" between hospital and community. At times this has given the illusion of ineffective treatment in the community, when in effect it is lack of sufficient community resources. Issues such as prevention,

early detection of problems, and reduced hospitalization or institutionalization will unlikely be resolved until a strong community resource base is developed.

This inadequate community resource base has a profound effect on the psychogeriatric population, because of the need for greater consistency in environmental surroundings of this age group. For the elderly, disturbances in the environment can create or exacerbate a problem. For example, admission to hospital may compound an existing problem and concomitantly distort the clinical assessment. Without adequate resources in the community particularly for assessment, a true clinical picture of the elderly person cannot be obtained.

It should be noted that there is a range of resources in the community; however, these resources are neither specialized to meet the needs of the psychogeriatric population, nor are they sufficient in numbers. Areas of major deficiency are support to caregivers, and self-help and advocacy groups.

d) heavy reliance on hospital/institutional treatment - There continues to be a heavy reliance on hospital/institutional care and treatment, due to the lack of community alternatives and the present

funding structures which restrict the growth of community resources and support the expansion of hospital/institutional resources. This continued reliance is of particular relevance to the elderly population who have the greatest number of hospitalizations and the longest average length of stay of any age group (refer to Appendix XII: Total Hospitalization by Age Group, 1985-86). For the psychogeriatric client there are few alternatives except the hospital/institutional sector. Although there are no statistics available, it is conceivable that many elderly treated in the hospital/institution could be more effectively treated in their home environment, at less cost and over a shorter period of time. There is unanimity from all sectors of health care that community alternatives must be developed, together with a reduction in hospital/ institutional care. With the elderly being the greatest consumers of health care, it becomes essential to develop viable community resources.

e) regional disparities -

Regional disparities have posed one of the most difficult challenges to the planning of provincial services. Despite major efforts to decentralize the resource base, there remains a concentration

of resources in urban settings marked by a total void, at times, in more isolated areas.

Unless these regional disparities are reduced, the existing problems will be magnified as mental health needs grow in tandem with the expanding geriatric population.

In order to develop a viable model for psychogeriatric service delivery, these present deficiencies in the mental health system will have to be addressed. Without an adequate foundation of general mental health services, the psychogeriatric component will not have the same degree of effectiveness, due to its interdependence with other components of the mental health and health care system.

The deficiencies outlined in this report and other specific elements required for psychogeriatrics will require major systemic reform. Although reform is currently being studied, the planning committee wished to reiterate the need for such reforms and to highlight those reforms particularly relevant to mental health and, therefore, to the psychogeriatric population.

The shape and scope of psychogeriatric services in the future will, to a large degree, be determined by the direction of mental health services in general. If present trends continue, the movement towards the community-based services and away from institutional care will facilitate

the implementation of a community-based model of service delivery to seniors. Principles of early detection of problems, prevention and treatment within a person's natural environment will be more easily operationalized within this paradigm.

Recommendations: Systemic Issues
12. Community resource base be expanded.
13. The Mental Health Division's role in planning and coordinating all sectors of the provincial mental health system be strengthened and given the mandate to implement the model for psychogeriatric service delivery.

4:06 Target Population

Psychogeriatric service has been defined by the planning committee as a range of specialized services that address themselves to mental illness or impairment in later life. Psychogeriatrics, geropsychiatry or geriatric psychiatry refers to the multi-disciplinary practice in the assessment and treatment of these disorders from a bio-psycho-social perspective. In diagnostic terms, psychogeriatrics primarily encompasses functional disorders (depression, anxiety states, paraphrenia) and organic disorders (Alzheimer's disease, multi-infarct dementia and mixed).

The proposed psychogeriatric services will focus primarily upon the people who experience their first onset of mental illness around the age of 65 or over. There are some individuals under 65 whose cognitive impairment is related to a disease associated with aging, who would be most appropriately served by access to psychogeriatric care. Similarly, there may be some individuals who have experienced mental illness during their lifetime, but require the specialized services of psychogeriatrics in their advanced years.

There is also a category of elderly persons whose behaviour appears to be psychiatric in nature and will require the comprehensive, specialized assessment capacity of psychogeriatric services, in order to determine the origin of the problem and the service most appropriate to meet the individual's needs. Because some physical problems in the elderly mimic psychiatric disorders, it is necessary for psychogeriatrics to work in close concert with physical medicine particularly in the diagnostic phase.

Finally, there are some elderly persons with a dual diagnosis of mental illness and retardation that could benefit from psychogeriatric services. However, psychogeriatric services will not deal with the general population of mentally retarded elderly.

Recommendation: Definition of Target Population

14. The target population for psychogeriatrics be defined as follows (in order of service priority):

* People who experience the first onset of mental illness at the age of 65 or over.
* People who are under the age of 65 and whose cognitive impairment is related to a disease associated with aging.
* Elderly people who have experienced mental illness throughout their lifetime and due to the interaction of the course of the disease together with their maturation require the specialized services of psychogeriatrics.
* Elderly people with the dual diagnosis of mental illness and mental retardation.

4:07 Conceptual Model

The draft guidelines from Health and Welfare Canada were used in developing the conceptual model for the delivery of psychogeriatric services, with specific focus on the clinical, resource development and structural areas (refer to Appendix XIII: Guidelines for Comprehensive Services to Elderly Persons With Psychiatric Disorders). They are consistent with the general guidelines for the development of mental health services in Manitoba, (refer to Appendix XIV: Guidelines for Development of Mental Health Services in Manitoba).

The two sets of guidelines highlight common elements that are required for comprehensive services to the psychogeriatric population. These elements include:

* multi-disciplinary nature of services.
* community-based service delivery and resource sectors.
* a range of services to meet the multiple needs of elderly persons.
* easy accessibility of services.
* effective coordination of services

These guidelines form the cornerstone of the following conceptual model for the delivery of psychogeriatric services.

Description of Model

The conceptual model that is proposed for Manitoba is designed to interlock and utilize the existing components in the Mental Health and Health Care Systems. Because this model is not free-standing, its effectiveness is contingent on the following factors being operational in the system:

* reorganized mental health system proposed in the mental health reform plan, supported by the psychogeriatric planning committee.
* adequate community resource base
* qualified, trained personnel

To address the broad range of services that are often required by the elderly population, it is necessary to develop and maintain close linkages between the service and resource sectors.

Due to the complexity in assessing and treating elderly persons with psychiatric disorders, some specialization within the existing service components

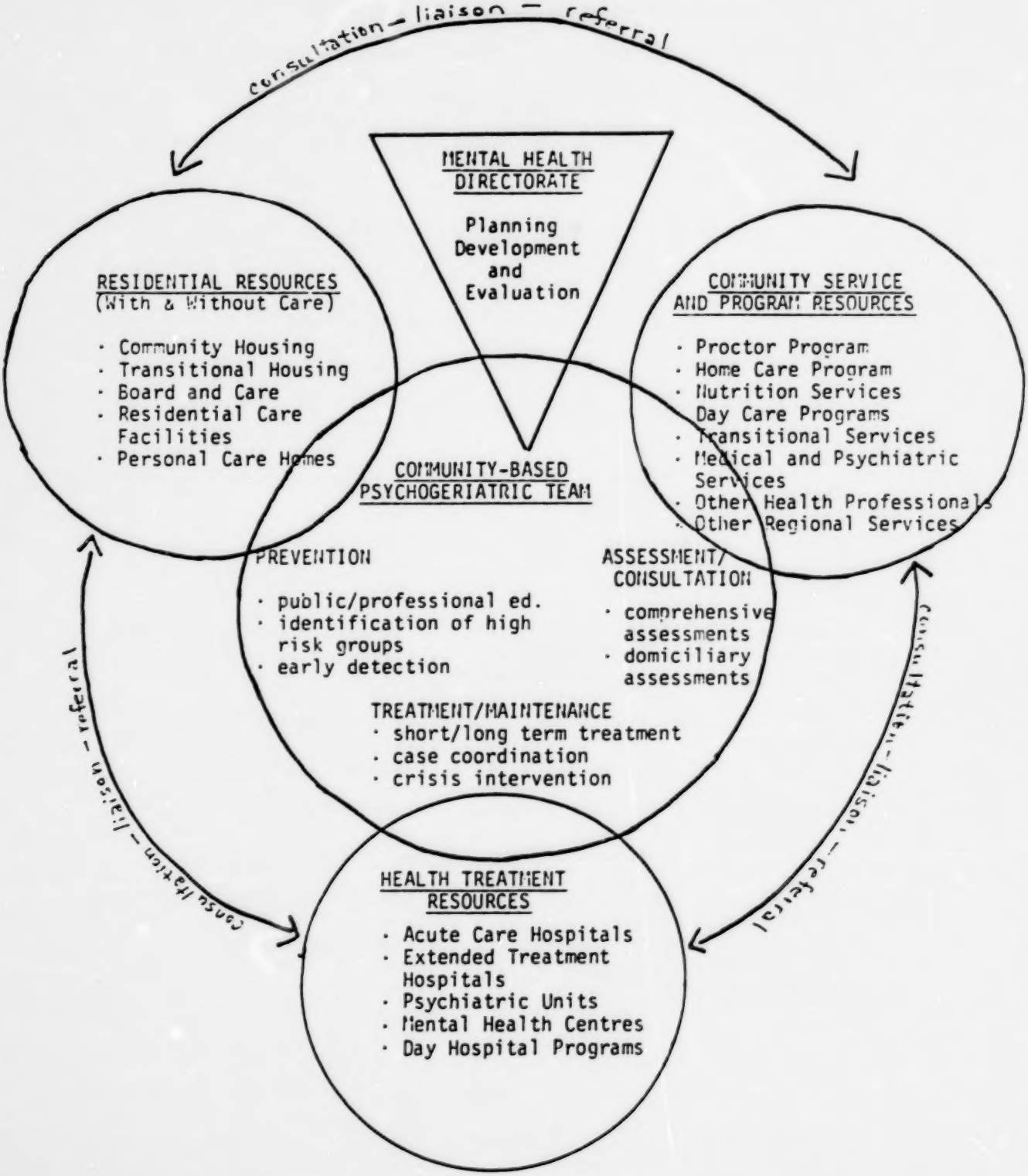
is required of this model. This specialization is in the form of multi-disciplinary, psychogeriatric teams based in the community. These teams form the main support to, and are the integrative factor in, both the formal and informal psychogeriatric service delivery system.

The diagram on page 46 depicts the model for the delivery of psychogeriatric services in Manitoba and includes the following service components:
a) prevention; b) assessment/consultation; and
c) treatment/maintenance.

I. Community-Based Psychogeriatric Team

The community-based psychogeriatric team offers a specialized service within the service delivery system. In order to ensure the specialized nature of this service, it is necessary that some level of prescreening be done by a community practitioner (either medical or non-medical) or program. Prescreening further highlights the need for incorporating psychogeriatrics into existing educational curriculae, particularly for physicians who are often the first contact for an elderly person requiring service.

MODEL OF PSYCHOGERIATRIC SERVICE DELIVERY



The main emphasis of any psychogeriatric team is on prevention, assessment, and assisting community practitioners in operationalizing treatment plans, particularly in cases where the practitioner's involvement has been long standing. In this regard it utilizes the existing professional resources whenever possible. The team has the capacity to provide short or long term treatment/maintenance, based on individual case requirements and regional needs.

As mentioned, the psychogeriatric team is staffed by professionals representing a range of disciplines. Each professional contributes to the assessment and treatment of cases, as required, with the function of case coordination shared by all members of the team.

Due to the specialized nature of the team, it offers an excellent multi-disciplinary training ground for professionals in psychogeriatrics. Since few community services have the scope found in this model, it becomes an ideal placement for training in conjunction with a hospital rotation or by itself. While the team's mandate is not research, it will be one of the primary sources for data collection, both for clinical as well as program purposes. Due to its strategic position as the main support of psychogeriatric service delivery, the team has the capacity to generate relevant data on

the future direction of psychogeriatric services in the province.

The following service components are offered by this community team:

a. Prevention:

* early detection of problems
* identification of high risk groups
* public/professional education

The psychogeriatric team emphasizes primary and secondary prevention in its service delivery, the former preventing problems from manifesting themselves and the latter preventing further deterioration of problems. Without input at this level more services will be required at a tertiary level, which are generally the most costly of the health care system.

An effective preventative program includes the following elements:

early detection or problems - with few exceptions early intervention can either eliminate an elderly person's problem or slow down the deterioration process, thereby allowing a longer stay at home and improving quality of life.

identification of high risk groups - One of the components of detecting problems at an early stage is the identification of high risk groups. As further research is generated on the psycho-

geriatric group, more sophisticated techniques will be developed in identifying groups of elderly people who are at risk for developing mental health problems.

public/professional education - At the core of any effective primary or secondary preventative program is public and professional education. While this must be viewed as a long-term, ongoing process, it is nevertheless essential to enhancing the quality of life and reducing the extent and severity of problems overall.

b. Assessment/Consultation:

* comprehensive assessment capacity
* domiciliary assessments
* consultation

comprehensive assessment capacity - Since the foundation of any effective treatment plan is the assessment, the psychogeriatric team has access to a comprehensive range of assessment undertaken by health care professionals. Particularly in the elderly, where physical health plays a major role in the diagnosis, a full range of health care skills are required.

In order to ensure access to this range of skills it is necessary that the team maintains an integral working relationship with the

medical community (hospitals, specialty medical/psychiatric services, private physicians) in order to have immediate access to diagnostic services.

At intake, an initial determination is made as to the kinds of input that are necessary for assessment purposes, although some of the assessment may in fact already have been completed by the referral source. If the assessment is coordinated by a team member, then alterations to the assessment will occur as more information is gathered. The end product will be a comprehensive assessment individually tailored to meet the needs of the case.

During the assessment process, it may be determined that the person requires more extended periods of observation to complete the assessment, such as partial hospitalization in a day hospital or full hospitalization. By placing the initial assessment function in the community, it will ensure that the more costly health care resources are used judiciously.

By utilizing the general hospital resources as part of the assessment process, the assessment and treatment planning remains in the community where a community-based plan can be enacted. Without the planning process being

located in the community, there is a tendency for institutional resources to become an end in and of themselves with little or no back and forth movement of patients to their home. With any service rendered, it is important to follow-up the case to ensure that recommendations have been useful and properly implemented.

domiciliary assessments - Because of the specific needs of the geriatric population, the assessment service requires a mobile response capacity to make timely domiciliary visits. This domiciliary assessment provides vital information on the person's living environment, that may be one of the keys in determining the feasibility of the person remaining at home. It will often determine the kind and scope of support services required in an effective treatment plan.

consultation - Consultation is also an essential component to the psychogeriatric team. In many cases consultation with a community practitioner, residential staff, community programs, or family can provide sufficient information to enhance the health or care provider's skill in dealing effectively with the case.

The level and intensity of consultation may range from a brief telephone conversation to assisting staff or family in developing and operationalizing a more effective treatment plan.

c. Treatment/Maintenance:

* short/long-term treatment
* crisis intervention

short/long-term treatment - A range of treatment/maintenance services will be offered to complex cases where there are no appropriate resources in the community. In these cases, the psychogeriatric team will assume the case coordination function, drawing on community resources and resources of other programs as required. The team will also identify gaps in the available range of services that attempt to meet the specialized needs of the psychogeriatric client. Given an appropriate assessment in some cases a maintenance or monitoring function will be warranted when active treatment is not indicated.

Treatment services may be time limited and designed to ameliorate one or more of the identified problems. Under these conditions a clear contract will be established with the care provider and/or community professional/

agency as to the duration, roles and responsibilities. In all cases, treatment will include a teaching component to impart the knowledge and skills to the care provider, whether it be a family member or community agency, for the ongoing care and treatment of the elderly person.

crisis intervention - As part of the treatment services, crisis intervention may be required with active cases. This intervention will focus on alleviating the presenting problem, preventing further deterioration and maintaining the clients in their environment. Wherever possible, the focus of the crisis intervention, as well as the treatment plan, is to facilitate a person remaining in the community. Towards this end, additional resources in the home may be necessary, such as appropriately trained homemakers, respite to family care providers, and adult day care.

II. Resource Network

The community model of psychogeriatric service delivery is not intended to duplicate or parallel existing services. For this reason, relevant services and resources have been identified within the existing network. The services/resources identified in the model are not exhaustive, nor do they preclude any

future requirements for expansion in the service and resource sectors. Development of resources will be more accurately determined when the model is operationalized and a clearer analysis of the needs occur.

As identified in the model, there are three major categories of resources:

i) Community service and program resources

ii) Health Treatment Resources where intensive clinical services are available

iii) Residential resources

Each of these categories contains a range of resources, generally varying with intensity of care and treatment in order to accommodate the multiple needs of psychogeriatric cases.

The community-based psychogeriatric team requires effective access to the resource network, in order to complete an assessment and/or operationalize a treatment plan. Ensuring access requires a formal interface with each resource that clearly outlines roles and responsibilities. This formalized interface will avoid potential duplication, enhance coordination and ensure effective utilization of all services.

On a one-to-one basis with community professionals, the necessity to develop strong interface is no less significant although perhaps less formal. It is paramount to the effective operation of the model to

establish good working relationships with individual health and community service practitioners, who form the backbone of service delivery in general in the community. It is through these individuals that an interchange of information and ideas occur and joint treatment planning is done, often with the community practitioner's continuing involvement in treatment.

III. Structure

The psychogeriatric team must be responsible to the departmental regional structure. This provides a community base, a single entry, and integration with existing services.

This model requires a planning capacity at the regional level to be responsive to regional needs. Province-wide planning and the establishment of provincial standards occur at the Mental Health Division to ensure uniformity and quality of service.

Linkages must be established with university faculties to develop appropriate training and research sites. This is absolutely essential in ensuring an adequate supply of psychogeriatric specialists for clinical work and training of other professionals.

Recommendations: Implementation of Model

15. The model for the delivery of psychogeriatric services be adopted. Key features of the model include:
    * multi-disciplinary nature of services.
    * community-based service delivery and resource sectors.
    * a range of services to meet the multiple needs of elderly persons.
    * easy accessibility of services.
    * effective coordination of services.

16. The Mental Health Division allocate a senior position along with adequate resources to be responsible to plan and coordinate the psychogeriatric service delivery system ensuring integration of services within the mental health system and the broader health care system.

17. Regional planning groups be struck to complete a needs analysis and to develop a long range plan for mental health services in the region with specific reference to the psychogeriatric population.

18. Two pilot projects be implemented, utilizing the proposed model for psychogeriatric service delivery, training and research. The projects should be undertaken in both a rural and urban site (refer to Appendix XVI: Pilot Project: Proposed Implementation Process).

4:08 Service Principles

In order to effectively implement the model for the delivery of psychogeriatric services, it is necessary to articulate the principles that will shape the development of the actual service component.

These service principles are reflected in the federal and provincial guidelines and the National Canadian Mental Health Association's Framework for Support (refer to Appendix XVI: C.M.H.A.: Framework for Support). They are as follows:

* assessments of persons with psychiatric disorders should be comprehensive in nature.
* assessments should reflect an integration of medical and psychiatric expertise.
* domiciliary assessments should be incorporated into all assessment formats.
* assessments should be multi-disciplinary in nature.
* the first course in assessment and treatment should be the least disruptive to the elderly person whenever possible.
* a continuum of treatment options should be available with emphasis on home and community-based interventions.
* ongoing treatment planning should occur to meet the changing needs of the elderly person.
* the care provider's role in the care and treatment of the elderly person should be strengthened and supported.
* an elderly person's natural support system (family, friends, neighbours) should be incorporated into the treatment planning process.

* the right of the elderly person to actively participate in the treatment planning/ decision making process should be ensured.

* in cases where the elderly person's ability to actively participate is severely impaired the family should be involved wherever possible.

* advocacy should be considered an inherent part of a professional's role in their work with elderly persons.

Recommendations: Service Principles
19. The above service principles be adopted for the future development of psychogeriatric services in the province.

5. CONCLUSION AND SUMMARY OF RECOMMENDATIONS

One of the major threads throughout the report is the interrelationship between psychogeriatrics and the general mental health system. Because of this interconnection, proposed recommendations on psychogeriatric service delivery are, in part, contingent on general mental health reform. Without a broader systems reform, the fate of psychogeriatrics is destined to be the fragmented, uncoordinated service delivery system of the present.

Recommendations that are set forth in this report address themselves to a series of measures, some of which can be implemented immediately, some requiring intensive planning and some requiring planning and fiscal expenditure. In order to assist with the priorization of recommendations, the Committee has divided them into three categories:

* those that can be acted on immediately (Recommendations 1, 2, 5, 11, 13, 14, 15, 16, and 19).
* those that require lead time for planning purposes (Recommendations 3, 4, 6, 7, 9, and 17).
* those that require lead time for planning and more fiscal resources. (Recommendations 8, 10, 12, and 18).

The Committee assigns highest priority to the implementation of Recommendation #18, that pilot projects utilizing the model of psychogeriatric services be implemented, acknowledging the planning and fiscal resources.

The following summarizes the recommendations and strategies for action:

Data Collection and Research

Immediate 1. Improvements be made be to existing data collection systems that will allow for expansion and standardization.

Immediate 2. Research into psychogeriatrics be encouraged through redirection of existing research monies.

Planning 3. A comprehensive needs analysis of psychogeriatric population be undertaken, in each region as part of the long range planning process.

Key Sectors in Mental Health

Planning 4. Linkages be developed between the hospital and community sectors to ensure continuity of care, availability of resources, sharing of information and joint treatment planning.

Immediate 5. An interface between Continuing Care and Community Mental Health programs be developed outlining the responsibilities of each in the development of resources to respond to the specialized needs of the psychogeriatric client.

Organizational Structure and Fiscal Distribution

Planning 6. Consideration be given to unifying the key components of the mental health system into one administrative and fiscal structure.

Planning 7. A more equitable distribution of fiscal and human resources occur between the hospital/ institutional sector and the community sector.

Planning & Fiscal 8. A specific allocation of mental health resources be targeted to meet the needs of psychogeriatric population.

Training

Planning 9. Manitoba Health invite the universities to participate in the joint development of training, education and research programs in psychogeriatrics where all mental health related disciplines can build knowledge and skills in the care of psychogeriatric clients.

Planning & Fiscal 10. Current and future service sites for psychogeriatric services should provide clinical training and inservice/staff development opportunities for practitioners and become an integral part of the proposed training at the universities.

Immediate 11. Related educational programs be encouraged to incorporate psychogeriatrics as a component of their curriculae.

Systemic Issues

Planning & Fiscal

12. Community resource base be expanded.

Immediate 13. The Mental Health Division's role in planning and coordinating all sectors of the provincial mental health system be strengthened and given the mandate to implement the model for psychogeriatric service delivery.

Definition of Target Population

Immediate 14. The target population for psychogeriatrics be defined as follows (in order of service priority):

* People who experience the first onset of mental illness at the age of 65 or over.
* People who are under the age of 65 and whose cognitive impairment is related to a disease associated with aging.
* Elderly people who have experienced mental illness throughout their lifetime and due to the interaction of the course of the disease together with their maturation require the specialized services of psychogeriatrics.
* Elderly people with the dual diagnosis of mental illness and mental retardation.

Implementation of Model

Immediate 15. The model for the delivery of psycho-geriatric services be adopted. Key features of the model include:

* multi-disciplinary nature of services.
* community-based service delivery and resource sector.
* a range of services to meet the multiple needs of elderly persons.
* easy accessibility of services.
* effective coordination of services.

Immediate 16. The Mental Health Division allocate a senior position along with adequate resources to be responsible to plan and coordinate the psycho-geriatric service delivery system ensuring integration of services within the mental health system and the broader health care system.

Planning 17. Regional planning groups be struck to complete a needs analysis and to develop a long range plan for mental health services in the region with specific reference to the psychogeriatric population.

Planning & Fiscal 18. Two pilot projects be implemented, utilizing the proposed model for psychogeriatric service delivery, training and research. The projects should be undertaken in both a rural and urban

site (refer to Appendix XVI: Pilot Project: Proposed Implementation Process).

Service Principles

Immediate 19. The following service principles be adopted for the future development of psycho-geriatric services in the province:

* assessments of persons with psychiatric disorders should be comprehensive in nature.
* assessments should reflect an integration of medical and psychiatric expertise.
* domiciliary assessments should be incorporated into all assessment formats.
* assessments should be multi-disciplinary in nature.
* the first course in assessment and treatment should be the least disruptive to the elderly person whenever possible.
* a continuum of treatment options should be available with emphasis on home and community-based interventions.
* ongoing treatment planning should occur to meet the changing needs of the elderly person.
* the care provider's role in the care and treatment of the elderly person should be strengthened and supported.
* an elderly person's natural support system (family, friends, neighbours) should be incorporated into the treatment planning process.
* the right of the elderly person to actively participate in the treatment planning/decision making process should be ensured.

* in cases where the elderly person's ability to actively participate is severely impaired the family should be involved wherever possible.

* advocacy should be considered an inherent part of a professional's role in their work with elderly persons.

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APPENDIX I

MEMBERSHIP OF COMMITTEE

Dr. Beth Atchison
Consultant/Psychiatrist

Don Gibson
Regional Coordinator of Mental Health
Eastman Region

Eckhard Goerz
Program Specialist - Social Work
Continuing Care

Betty Havens
Provincial Gerontologist

Edie Heinrichs
Nursing Consultant
Rural Health Facilities Division
Manitoba Health Services Commission

Dr. Anwar Islam
Program Specialist - Mental Health
Mental Health Directorate

Mike Kufflick
Chief Executive Officer
Brandon Mental Health Centre

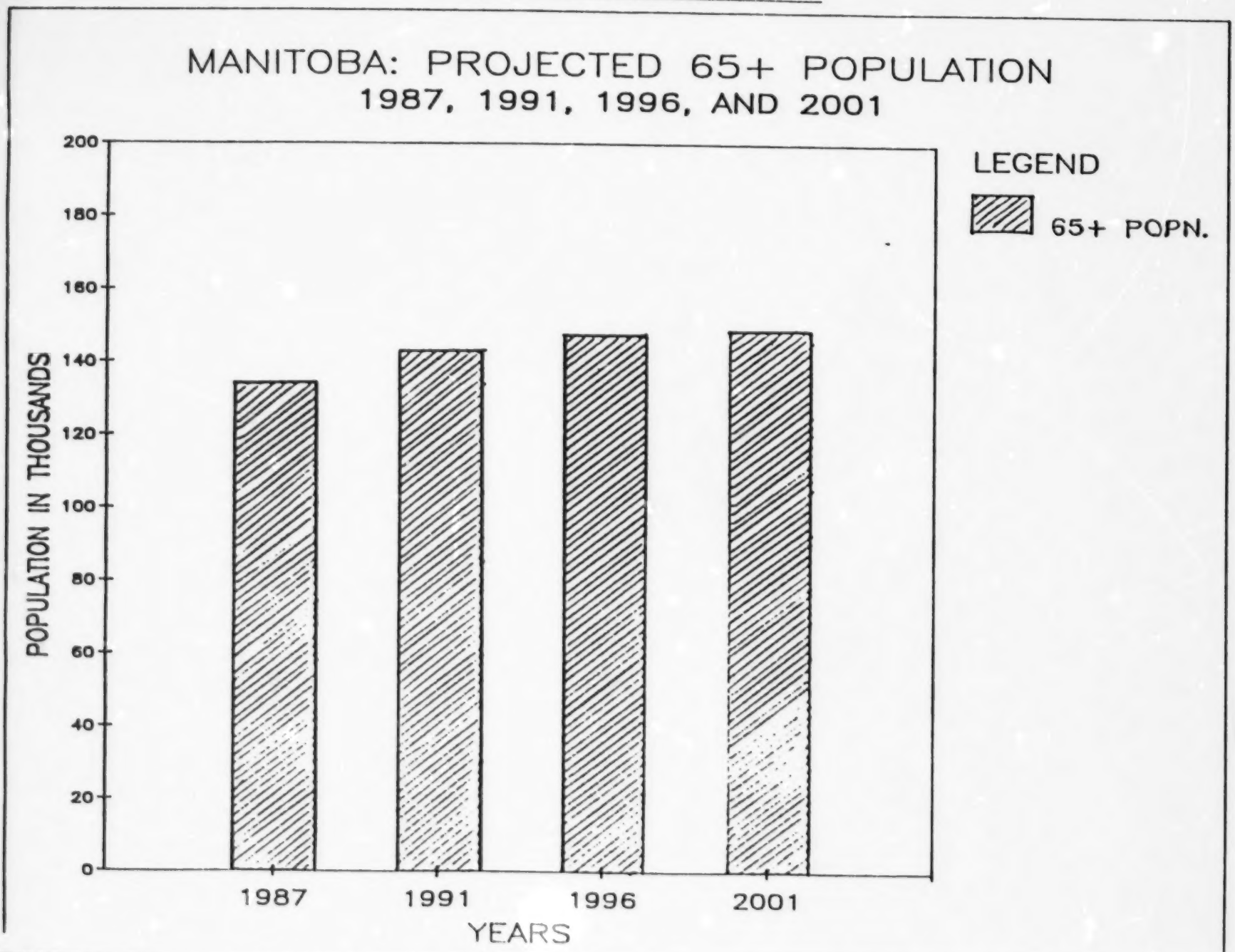
Marg Redston
Senior Consultant
Long-Term Care Programs Division
Manitoba Health Services Commission

Maxine Topley
Program Specialist - Mental Health
Mental Health Directorate

Tom Walters (Chair)
Director
Mental Health Directorate

APPENDIX II

POPULATION PROJECTIONS FOR MANITOBA



APPENDIX III

DAY HOSPITALS: PSYCHIATRIC PROBLEMS IN ELDERLY PATIENTS

N=51

Rank Ordering of Psychiatric Diagnosis	No. of Day Hospital Participants
1st	14*
2nd	8
3rd	9
4th	3
5th	none
6th	2
TOTAL	36 **

* Approximately 27.5% of the total sample have a primary psychiatric diagnosis.

** This survey was compiled on all Day Hospitals in Winnipeg with the exception of The Seven Oaks Psychogeriatric Day Hospital. The final figure of 36/51 contains some cases with more than one psychiatric diagnosis.

Source: Research and Planning, Day Hospital Study, April, 1985

APPENDIX IV

PERCENTAGE OF PERSONAL CARE HOME RESIDENTS WITH A PSYCHIATRIC DIAGNOSIS, BY REGION

Region	Total No. of Residents	% of Residents with Psychiatric Diagnosis
Central	756	29%
Eastman	383	23%
Interlake	549	23%
Norman	157	29%
Parklands	395	27%
Westman	1459	24%
Winnipeg	4546	29%
TOTAL:	8245	28%

Source: M.H.S.C., Long-Term Care Programs Division, March 31, 1986

APPENDIX V

1986 COMMUNITY MENTAL HEALTH CASES: BY AGE AND REGION

	0 - 17	18 - 64	65+
CENTRAL	21	199	28
EASTMAN	3	327	108
INTERLAKE	6	178	61
NORMAN	9	151	21
PARKLANDS	17	190	78
THOMPSON	15	177	4
WESTMAN	46	333	186
WINNIPEG (3 regions combined)	1	679	437

Source: Mental Health Directorate, December 1986.

APPENDIX VI

RESIDENTIAL CARE FACILITIES

REGION	# M.H. Beds in Approved Homes as of Mar/86	# M.H. Beds in Approved Homes as of Jan/87	# M.H. Beds in Licensed Facilities as of Mar/86	# M.H. Beds in Licensed Facilities as of Jan/87
3 WINNIPEG Regions Combined	90	76	244	248
INTERLAKE	5	10	6	0
EASTMAN	27	25	0	0
WESTMAN	77	79	75	74
CENTRAL	14	14	8	8
PARKLANDS	25	25	25	25
NORMAN	0	0	0	0
THOMPSON	0	0	0	0
TOTAL	238	229	358	355

NOTE: These figures do not include some elderly mental health clients who are residing in Aged and Infirm facilities.

APPENDIX VII

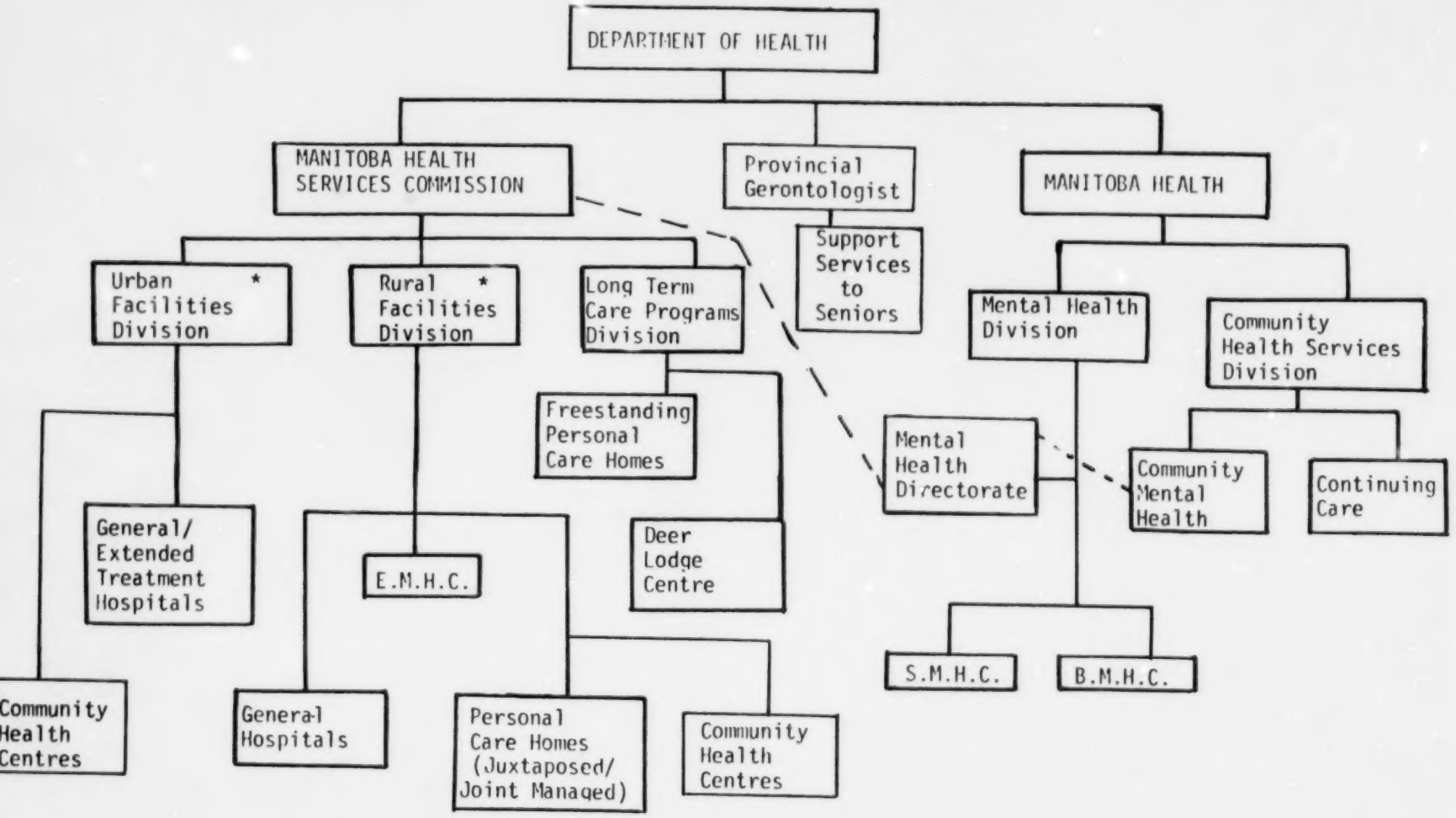
ADULT DAY CARE

Region	# of Day Care Programs	# of Participants
Central	7	108
Eastman	6	61
Interlake	8	69
Norman	1	7
Parklands	2	11
Thompson	1	4
Westman	16	110
Winnipeg	14	544
Provincial	55	914

Source: M.H.S.C., Long Term Care Programs Division, December, 1987 (Statistics from April - September, 1987 inclusive).

APPENDIX VIII

ORGANIZATIONAL STRUCTURE OF HEALTH:
KEY COMPONENTS OF THE PSYCHOGERIATRIC SYSTEM



* Board of Directors manage the public/non-profit facilities.
Corporate bodies manage the for-profit facilities.

APPENDIX IX

MENTAL HEALTH SERVICES : ESTIMATED EXPENDITURES 1981/82 TO 1986/87

TYPE OF SERVICE	1981/82	1982/83	1983/84	1984/85	1985/86	1986/87
Acute and Extended Hospital Care	32,072.4	35,340.8	39,647.2	46,947.8	54,380.9	67,637.3
Personal Care Homes	23,989.9	30,022.8	37,415.3	39,458.3	42,555.0	43,648.4
Mental Health Centres:						
Selkirk MHC	11,309.8	12,751.4	14,849.2	14,660.7	14,623.4	15,214.9
Brandon MHC	14,074.1	16,083.0	19,032.0	18,716.3	18,777.4	18,992.2
Eden MHC	1,253.4	1,492.7	1,755.9	2,018.1	2,197.7	2,439.1
SUB-TOTAL MHC:	26,637.3	30,327.1	35,637.1	35,395.1	35,598.5	36,646.2
Forensic Services	444.3	487.7	611.0	579.4	599.1	604.0
INSTITUTIONAL SECTOR SUB-TOTAL:	83,143.9	96,178.4	113,310.6	122,380.6	133,133.5	148,535.9
(as % of TOTAL)	86.7	87.1	87.4	87.9	87.5	87.7
Medical Services	9,147.5	10,176.8	11,456.0	12,039.6	13,025.8	14,522.4
Community Mental Health:						
Regional Services	2,000.0	2,160.0	3,004.1	3,189.9	3,653.6	3,932.0
MH Training	69.3	118.5	101.2	101.2	106.2	101.2
Child/Adolescent	756.2	845.2	1,002.3	956.0	1,043.0	828.3
Nursing Bursary	209.0	300.6	277.1	0.0	0.0	0.0
Community Residences	549.0	690.1	564.4	636.9	1,232.1	1,360.7
SUB-TOTAL CMH:	3,583.5	4,114.4	4,949.1	4,884.0	6,034.9	6,222.2
NON-INSTITUTIONAL SECTOR SUB-TOTAL:	12,731.0	14,291.2	16,405.1	16,923.6	19,060.7	20,744.6
(as % of TOTAL)	13.3	12.9	12.6	12.1	12.5	12.3
TOTAL:	95,874.9	110,469.6	129,715.7	139,304.2	152,194.2	169,280.5
INCREASE IN TOTAL EXPENDITURE (1981/82 = 100)	100	115	135	145	159	177

APPENDIX X

ESTIMATED STAFFING OF SERVICES RELATED TO MENTAL HEALTH BY DISCIPLINE AND BY WORK SETTING 1985-86

	NURSING	R.P.N. R.N. B.N.	SOCIAL WORK	PSYCHOLOGY	OCCUPATIONAL THERAPY	OTHER
INSTITUTIONAL SECTOR						
A) Brandon Mental Health Centre	193.0		19.0	11.0	4.5	-
B) Selkirk Mental Health Centre	163.0		11.0	7.0	5.0	-
C) Eden Mental Health Centre	(1) 10.4	R.P.N. & R.N.	(1) 3.8	(1) .8	(1) .2	-
D) General Hospitals: Psychiatric Units	(1) 99.2 (1) 115.7	R.P.N. R.N.	(2) 10.6	(2) 7.5	(2) 14.4	-
E) Personal Care Homes	(3) 26.8 (3) 399.6	R.P.N. R.N.	(4) 20.0	(4) 1.0	(5) 8.6	-
SUB-TOTALS:	1007.7		64.4	27.3	32.7	-
COMMUNITY SECTOR						
A) Community Mental Health Program	45.0		27.0	3.0	-	15.0
B) Continuing Care	230.0 82.0	R.N. B.N.	38.0	-	-	-
SUB-TOTALS:	357.0		65.0	3.0	-	15.0
TOTAL:	1364.7		129.4	30.3	32.7	15.0

NOTE
None of the above figures are pro-rated to reflect the estimated psychogeriatric caseloads nor has it been possible to accurately determine the actual numbers of physicians providing psychiatric services to the elderly.

(1) Actual reported EFT
(2) Positions also serve some patients outside of Psychiatric Units
(3) Positions reported in Nursing Manpower Survey Report - January 1986
(4) Actual funded positions
(5) EFT includes both CTSM therapists and facility-hired therapists.

APPENDIX XI

PROFESSIONAL TRAINING PROGRAMS

A. R.P.N. SCHOOL OF NURSING - S.M.H.C./B.M.H.C.

Course Work: Geriatrics
Growth and Development
(Note: Treatment and care of the psychogeriatric patient is integrated into all courses).

Clinical Placement: Basic nursing skills in psychogeriatric unit.

Community Placements: Personal Care Homes

B. SCHOOL OF SOCIAL WORK

Course Work: Working with Elderly Clients (elective)

Clinical Placements: Major geriatric settings - general hospitals; Age & Opportunity.

C. O.T. SCHOOL OF MEDICAL REHABILITATION: OCCUPATIONAL THERAPY DIVISIONS

Course Work:

Year I	Intro to Psychiatric Problems in Elderly	2 hours
Year II	Gerontology	15 hours
Year III	Psychogeriatrics	6 hours
Elective	Gerontology	45 hours

Clinical Placements: Non-Elective placement in a geriatric setting, most of which are psychogeriatric. Major psychogeriatric placements - Health Action Centre; Seven Oaks Hospital.

D. CLINICAL INTERNSHIP PROGRAM: SECTION OF BEHAVIOURAL SCIENCES, DEPARTMENT OF PSYCHIATRY

Clinical Internship: Elective 12 month internship at St. Boniface General Hospital, In-Patient Psychiatry/Geriatric Consultation.

E. FACULTY OF MEDICINE

a) Undergraduate

Course Work: Med. II Dept. of Psychiatry - Lecture series in psychiatry, including organic mental disorders.
Section of Geriatric Medicine - Seminar series on gerontology.

Med. III Dept. of Psychiatry/Family Practice
- Seminar series in psychiatry, including issues of the aging patient.

Med. IV Dept. of Psychiatry - Didactic series, including organic mental disorder.

Clinical Rotation: Elective 3 month rotation on geriatric medicine ward.

b) Postgraduate - Department of Psychiatry

Course Work: Year I Seminar Series in Geriatric Psychiatry.

Year II & III Elective Seminar Series in Geriatric Psychiatry.

Clinical rounds on topics pertinent to geriatric medicine and geriatric psychiatry.

Clinical Rotation: Elective 3,6 and 12 month rotations at St. Boniface General Hospital under the supervision of a geriatric psychiatrist.

APPENDIX XII

TOTAL HOSPITAL UTILIZATION BY AGE-GROUP: MANITOBA, 1985/86

Age-Group	No. of Separations	No. of Patient Days	Average Length of Stay	Percentage Distribution in Pop'n	Sep.	Pt.Days
0-14*	20,329	92,427	4.5	22.6	12.7	5.2
15-64	91,002	668,230	7.3	65.4	56.9	37.4
65+	48,665	1,024,525	21.1	12.0	30.4	57.4
TOTAL:	159,996	1,785,182				

* Excludes newborns

Source: M.H.S.C. Annual Statistics, 1985/86.

APPENDIX XIII

HEALTH & WELFARE CANADA GUIDELINES FOR THE DEVELOPMENT OF COMPREHENSIVE SERVICES TO ELDERLY PERSONS WITH PSYCHIATRIC DISORDERS

I. Clinical Guidelines:

* comprehensive assessment and treatment capacities.
* use of domiciliary assessments as a first step in assessment procedure.
* integration of medical and psychiatric services to address complex diagnostic requirements in the elderly.
* utilization of a broad range of services to meet individual needs.
* flexibility in treatment planning to meet changing needs individuals.

II. Resource Development Guidelines:

* comprehensive range of services, on a continuum from minimal community supports to full institutional care.
* resources to facilitate client remaining in community as long as possible.
* expansion of community resource base.

III. Structural Guidelines:

* multi-disciplinary assessment for coordinated care planning.
* use of catchment areas as the basic geographic unit for coordinated services.
* single-entry service delivery for coordination of care systems.
* use of a case coordinator to coordinate the services to the individual patient.
* expansion of educational and training opportunities for those working with the elderly.
* modification of present methods of funding medical practitioners to encourage use of such procedures as domiciliary assessment, case coordination and multi-disciplinary team building and education.

* These guidelines are a brief synopsis of the Health & Welfare document.

APPENDIX XIV

C.M.H.A.: FRAMEWORK FOR SUPPORT

PRINCIPLES FOR SUPPORTIVE SERVICES:

The goal of successful community living for severely mentally disabled people requires the creation and maintenance of a system of supports and services with the following characteristics:

* Individualization The planning, arrangement and delivery of support are determined by the particular needs of the individual.

* Comprehensiveness The system responds to the individual as a whole person, delivering the necessary type and degree of support regardless of age or degree of disability.

* Integration Opportunities are maximized for the individual to participate in the mainstream of community life.

* Adaptability Supports and services are monitored and flexibility adjusted to remain appropriate and responsive to the individual as needs change over time.

* Coordination Existing and newly developed resources, supports and services are coordinated in a way to most effectively meet the needs of individuals and the entire population of severely mentally disabled people in a defined area.

* Developmental Orientation The individual is constantly encouraged to acquire the skills necessary to live, work and function successfully socially in the community.

* Mandated The responsibility for service planning, development, coordination and delivery for a defined area is clearly designated to some authority.

* Non-Stigmatizing All efforts are taken to present severely mentally disabled people in positive, valuing ways.

* Safeguarded The rights and interests of severely mentally disabled people are protected by advocacy bodies external to the system and free of conflict of interest.

Source: National C.M.H.A.

APPENDIX XV

GUIDELINES FOR THE DEVELOPMENT OF MENTAL HEALTH SERVICES IN MANITOBA

* The development of community-based services has highest priority in planning.

* The management of community-based services are to remain in the community.

* Mechanisms for coordinated treatment planning between hospital and community services are to be built into the planning base.

* Case coordination is to be located in the community with primary treatment responsibility determined by the needs of the client.

* Wherever possible, a multi-disciplinary approach is to be used in the delivery of mental health services.

* Planning of services are to focus on the least possible disruption of the client's lifestyle.

* Treatment planning should facilitate the client remaining in his/her home.

* The focus of mental health services is to restore the client to his/her optimal level of functioning.

* A continuum of mental health services should be planned to meet:
  a) varying intensities of need; and
  b) changing needs of individual clients.

* Access to other related programs and services to meet the specific needs of clients should be part of the planning process.

* Ongoing evaluation must be built into all programs at the planning stage.

* In-patient services should focus on redeployment of available beds. (No expansion until community programming needs have been studied vis-a-vis existing hospital services).

* Planning should incorporate a shift in the focus of out-patient services from hospital to community-based clinics.

* Residential resource development should focus on small community residences.

* Continuum of community residences reflecting different levels of intensity of care and treatment will be developed.

APPENDIX XVI

PILOT PROJECTS: PROPOSED IMPLEMENTATION PROCESS
- PSYCHOGERIATRIC SERVICE MODEL

1. The Assistant Deputy Ministers of Mental Health, Community Health Services Division the Associate Executive Director, Facilities, Manitoba Health Services Commission, and the Provincial Gerontologist form a steering committee to oversee the implementation of the two pilot projects.

2. A program planning committee be established, chaired by the Mental Health Directorate with program representation from Continuing Care, M.H.S.C. the Provincial Gerontologist to clearly outline programmatic goals, objectives and guidelines for a psychogeriatric model and to establish criteria for evaluation.

3. A Regional Implementation Team be established in two regions chaired by the Mental Health Coordinators with representation from key service providers in the regions (eg. personal care homes, general practitioners, hospitals, Continuing Care, etc.) to develop and implement a pilot project for psychogeriatric service delivery.

4. The Regional proposals be endorsed by the program planning committee and forwarded to the steering committee for approval.

5. Following committee approval the proposals be submitted as pilot projects for required funding.

6. Upon funding approval, the Regional Implementation Teams be asked to initiate and administer the pilot projects.

7. Evaluation of the projects be undertaken by an external (preferably university researcher in consultation with the Program Planning Committee) within 12 to 18 months of initiation of the projects.

8. Within 6 to 12 months following receipt of the evaluations, recommendations be provided on modification, expansion or continuation of the psychogeriatric service delivery model.